



Missouri Board of Pharmacy

Published to promote voluntary compliance of pharmacy and drug law.

PO Box 625, Jefferson City, MO 65102

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New Department for the Board of Pharmacy

Effective August 28, 2006, the Division of Professional Registration, the home agency for the Missouri Board of Pharmacy, was transferred from the Department of Economic Development to the newly formed Department of Insurance, Financial Institutions and Professional Registration (DIFP). Due to the transfer, the Board's 4 CSR 220 regulations will be renamed 20 CSR 2220. The Board's Web site link to regulations will be updated when the change occurs.

Recognitions and Awards

During the last year, Inspectors Bud Alexander and Tom Glenski received service awards from the Board for five and 10 years of employment, respectively. Congratulations to these employees for the well-deserved awards.

Continuing Education Audit

During the first quarter of 2007, the Board will be conducting its audit of pharmacists' continuing education (CE). As in the past, a random selection of pharmacists will receive correspondence at their current home addresses instructing them to submit proof of CE for the last renewal period. Only one mailing will be sent with no second attempts or reminders. Failure to produce the required CE will result in an assessment of a delinquent fee of \$500 as well as possible disciplinary action.

Pseudoephedrine Update

Effective August 28, 2006, **legend** pseudoephedrine-containing products are no longer controlled substances (CS) in Missouri. The annual inventory of these products is no longer required. Nurse practitioners and physician assistants can again prescribe them. This change did **not** affect the status of over-the-counter products.

Licensing Action Report

Pharmacists

- Mandana A. Dowlatshahi, #2006021556**, Lees Summit, MO. July 18, 2006. Restricted pharmacist license issued on probation for one year. Theft of merchandise from employer and inappropriate coupon use at place of employment. Section 338.055.1 and .2 (5) and (13), RSMo.
- James M. Groves, #029093**, Kansas City, MO. July 6, 2006. Violation of prior discipline. Negligent in assuring compliance with the regulations pertaining to the compounding of sterile products. Section 338.055.2(5), (6), and (15), RSMo.
- Martin J. Hinterlong, #042595**, Saint Clair, MO. August 15, 2006. Pharmacist license suspended for two weeks, followed by five years probation. Pled guilty to class C misdemeanor assault in the third degree; dispensed a drug without a prescription; misbranded drugs; as pharmacist-in-charge (PIC), failed to assure compliance with all state and federal laws concerning drug distribution and control; violated the professional trust and/or confidence placed in him by customers. Section 338.055.2(2), (13), and (15), RSMo.
- Robert T. Lawley, #2006026510**, Lebanon, MO. August 28, 2006. Restricted pharmacist license issued on probation for three years. Entered into a Stipulation and Final Agency Order with the Colorado State Board of Pharmacy. Section 338.055.1 and .2 (8), RSMo.
- Susann N. Nance, #029255**, Blue Springs, MO. August 5, 2006. Pharmacist license placed on probation for two years. Fraudulently billed the insurance companies of the patients for the prescriptions, which were filled without their request; stole, issued, and cashed gift cards associated with the selling of these unauthorized prescriptions to her parents; violated the patient confidentiality rule; returned fraudulently distributed medication and poured the contents into stock bottles, adulterating stock. Section 338.055.2(5), (6), (13), and (15), RSMo 2000.

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FDA Launches Consumer Educational Program on the Safe Use of OTCs

The United States Food and Drug Administration's (FDA) Center for Drug Evaluation and Research, in cooperation with the National Council on Patient Information and Education and Maryland's Montgomery County Public Schools, has launched "Medicines in My Home," an interactive educational program aimed at informing middle school students about the safe and effective use of over-the-counter (OTC) medicines. Key concepts students will learn from the program are:

- ◆ the Drug Facts label tells you what a medicine treats, if it is right for you and your problem, and how to use the medicine;
- ◆ read the label and follow the directions carefully and correctly;
- ◆ two medicines with the same active ingredient should not be used at the same time; and
- ◆ measure medicines correctly with measuring tools made for medicines.

The program emphasizes that medicines should be used only with permission from an adult and that if there are questions about medicine use, ask a pharmacist or doctor. Materials are provided to encourage students to share what they learn with their families so that all family members can learn to use OTC medicines more safely. Program information can be found at www.fda.gov/medsinmyhome.

HHS Warns Public of Heroin and Fentanyl Deadly Combo

In efforts to warn the public and health care professional communities regarding a recent rash of drug-related deaths due to an illicit street drug combination consisting of the prescription medication fentanyl and either heroin or cocaine, the Department of Health and Human Services (HHS) released a fact sheet containing specific information with the goal of saving lives.

A letter from H. Westley Clark, director of HHS Center for Substance Abuse Treatment, to health care professionals warned that in "just one week, an estimated 33 individuals in the Detroit, MI area are reported to have died after using this fatal mix of drugs; the same drug combination may have been responsible for more than 100 deaths in the same region last September [2005]." Philadelphia, PA; Chicago, IL; St Louis, MO; and Camden, NJ have also recently experienced similar clusters of drug-related deaths.

Fentanyl, an injectable Schedule II prescription opioid analgesic, is roughly 50 to 80 times more potent than morphine but can also be produced in clandestine laboratories in powder form and then mixed with or substituted for heroin. Fentanyl-related overdoses can result in sudden death through respiratory arrest, cardiac arrest, severe respiratory depression, cardiovascular collapse, or severe anaphylactic reaction. In some cases, heroin or cocaine users are aware they are purchasing this dangerous combination of drugs and in other cases, they are not. Because the potency of street-sold heroin or cocaine is amplified markedly by fentanyl and because the inclusion of fentanyl

may not be disclosed, any use, even a reduced dose, can result in overdose or death. The fact sheet advises that suspected overdoses should be treated rapidly with a naloxone injection, 0.4 to 2 mg intravenously, subcutaneously, or intramuscularly every two to three minutes, which should rapidly reverse symptoms related to a narcotic overdose; if there is no response after 10 minutes, then a different diagnosis should be considered.

For additional information, contact Kenneth Hoffman at the Substance Abuse and Mental Health Services Administration at 240/276-2701 or via e-mail at Kenneth.Hoffman@samhsa.hhs.gov.

Pharmacy Technicians and Medication Error Prevention



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

In an October 2005 article in the *American Journal of Health-System Pharmacists*, the results of a random nationwide survey of more than 800 pharmacy technicians' views about their medication errors was published (Desselle SP. Certified pharmacy technicians' views of their medication preparation errors and educational needs. *Am J Health-Syst Pharm*. October 1, 2005; 62:1992-97). Most of the technicians worked in community pharmacies, but more than a quarter (27%) were employed in hospitals.

As one might expect in both settings, interruptions and inadequate staffing were among the most frequent factors perceived to contribute to technician medication preparation errors. Inadequate staffing was perceived as especially problematic in chain pharmacies, while inadequate supervision by pharmacists was cited as a factor more frequently by hospital technicians. It also may come as no surprise that the pharmacists' most frequently cited response to an error that was caught during the checking process was to make the technician aware of the error and require him or her to correct it. However, only about 17% of the technicians reported that the pharmacist had used the error as an opportunity to provide instructions on how to avoid the same or similar errors in the future.

While many of these respondents attributed this responsibility to the organization as a whole, not necessarily the individual pharmacist who detects an error, it appears technicians may not be receiving guidance about system and process changes that can help avert errors. After an



error is corrected, the checking pharmacist should find time that same day (or the next day, if necessary) to review the error with the technician and suggest ways to avoid it, including safer behavioral choices if applicable. Later, during pharmacy staff meetings or other forms of intradepartmental communication, errors, their causes, and ways to prevent them should be shared with all staff in a way that does not embarrass those who were possibly involved in the errors.

One or Both Nostrils?

Submitted by ISMP

Although many nasal sprays are intended for administration in each nostril for a single dose, there are notable exceptions. For example, some medications are meant to be delivered via the nasal passage but **not** sprayed into each nostril. Calcitonin salmon (**Fortical**[®], **Micalcin**[®]) is a prime example. Patients should administer a single spray (200 international units) into one nostril daily, using alternate nostrils each day. Other examples in metered-dose or unit-dose nasal spray containers include butorphanol, desmopressin (**DDAVP**[®]), sumatriptan (**Imitrex**[®]), and zolmitriptan (**Zomig**[®]).

Some pharmacy and/or physician electronic prescribing systems have been preprogrammed to print directions that default to "spray in each nostril" when nasal sprays are selected. For the previously mentioned drugs, this would result in the administration of a double dose of medication. One health care facility recently reported that about 50 patients, who had been prescribed medications intended to be given into one nostril, had prescription container labels that instructed the patients to administer the spray into both nostrils. Some physicians might anticipate patients' confusion and write the prescription for "half" doses in each nostril. Even if instructed to use the spray in one nostril, patients who administer other nasal medications in both nostrils may spray these medications into both nostrils without thinking.

Explicit verbal directions and written instructions that emphasize administration via one nostril only are critical to avoid an overdose.

FDA/ISMP National Campaign to Help Eliminate Ambiguous Medical Abbreviations

FDA and the ISMP have launched a national education campaign that focuses on eliminating the use of potentially harmful abbreviations by health care professionals, medical students, medical writers, and the pharmaceutical industry. The campaign addresses the use of error-prone abbreviations in all forms of medical communication, including written medication orders, computer-generated labels, medication administration records, pharmacy or prescriber computer order entry screens, and commercial medication labeling, packaging, and advertising. For more information visit www.fda.gov/cder/drug/MedErrors.

DEA Provides Retail Training Materials

Drug Enforcement Administration (DEA) recently announced the availability of training materials regarding self-certification training for regulated retail sellers of non-prescription drug products containing

ephedrine, pseudoephedrine, and phenylpropanolamine as required by the Combat Methamphetamine Epidemic Act of 2005 (Title VII of Public Law 109-177).

Two sets of training materials have been developed: one for regulated persons who are mobile retail vendors, and one for regulated persons who are not mobile retail vendors. Both sets of training materials may be found on the Diversion Control Program Web site, www.deadiversion.usdoj.gov, under "Combat Methamphetamine Epidemic Act of 2005."

DEA notes that regulated sellers must use the content of these training materials in the training of their employees who sell scheduled listed chemical products. A regulated seller may utilize additional content in its training program, but DEA's posted material must be included.

DEA is continuing to work to promulgate regulations to implement the Combat Methamphetamine Epidemic Act of 2005.

FDA Announces Release of Guidance on Useful Written Consumer Medication Information

In the July 18, 2006 *Federal Register*, FDA announced the availability of a guidance entitled "Useful Written Consumer Medication Information (CMI)." This guidance is intended to assist individuals or organizations (eg, pharmacies, private vendors, health care associations) in developing useful written consumer medication information to comply with Public Law 104-180. CMI is written information about prescription drugs developed by organizations or individuals, other than a drug's manufacturer, that is intended for distribution to consumers at the time of dispensing. Since neither FDA nor the drug's manufacturer reviews or approves CMI, FDA recommends that the developers of written medication information use the factors discussed in this guidance to help ensure that their CMI is useful to consumers.

This guidance can be accessed at www.fda.gov/cder/guidance/7139fnl.htm.

2007 Survey of Pharmacy Law Available Soon

NABP's 2007 *Survey of Pharmacy Law* CD-ROM will be available in early December 2006. New topics include whether or not licensure for wholesale distributors of non-prescription drugs is required and the recognition of Verified-Accredited Wholesale Distributors[®] accreditation.

The *Survey* consists of four sections: organizational law, licensing law, drug law, and census data. The *Survey* can be obtained for \$20 from NABP by downloading the publication order form from www.nabp.net and mailing in the form and a money order to NABP. The CD-ROM is provided free of charge to all final-year pharmacy students through a grant from AstraZeneca Pharmaceuticals. If you do not have Web access or would like more information on the *Survey*, please contact NABP at 847/391-4406 or via e-mail at custserv@nabp.net.

John H. Peer, #028198, Kansas City, MO. August 26, 2006. Pharmacist license placed on probation for five years. Failure to maintain original prescriptions in the appropriate prescription files; maintain pharmacy in a clean and sanitary condition; maintain proper files of prescriptions; keep pharmacy inventory separate from outdated supplies; keep the daily pharmacist signature log signed; keep the compounding area in a sanitary condition; properly dispose of CS; properly maintain records of CS; maintain a Schedule II CS in a secured area; and as PIC, failure to comply with all state and federal laws. Section 338.055.2(5), (6), and (15), RSMo.

Chalen E. Reed, #2005021435, Horton, KS. August 31, 2006. Restricted license on probation for four years. Use and addiction to benzodiazepines, impairment, practiced as a pharmacist prior to licensure. Section 338.055.1 and .2(1) and (6), RSMo Supp. 2003.

Shawn P. Reidy, #041667, Leawood, KS. September 10, 2006. Violation of previous discipline. Pharmacist license suspended for three months followed immediately by probation for five years. Failed to call for testing services to determine compliance with required abstinence from alcohol consumption; tested positive for alcohol on at least two occasions. Section 338.055.2(6) and (13), RSMo.

Pamela L. Stoddart, #041867, Platte Woods, MO. September 10, 2006. Violation of prior discipline. Pharmacist license placed on suspension for seven days followed immediately by probation for three years. Tested positive for alcohol on two occasions. Section 338.055.2(6) and (13), RSMo.

Pharmacies

Center Pharmacy, #003570, Kansas City, MO. August 26, 2006. Pharmacy permit placed on probation for five years. Failure to: maintain original prescriptions in the appropriate prescription files; maintain the pharmacy in a clean and sanitary condition; maintain proper files of prescriptions; keep pharmacy inventory separate from outdated supplies; keep the daily pharmacist signature log signed; keep the compounding area in a sanitary condition; properly dispose of CS; properly maintain records of CS; and maintain a Schedule II CS in a secured area. Section 338.055.2(5), (6), and (15), RSMo.

Medicine Shoppe, #005448, St Clair, MO. August 15, 2006. Pharmacy permit placed on probation for five years. Dispensed a drug without a prescription; misbranded drugs; failed to assure that all state and federal laws concerning drug distribution and control were complied with so that no violations occurred causing a drug to be misbranded; violated the professional trust and/or confidence placed in the pharmacy by customers. Section 338.055.2(5), (6), and (15), RSMo.

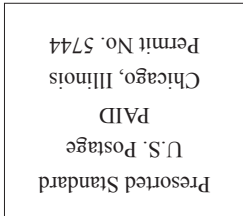
Medicine Shoppe (the), #005049, Gladstone, MO. July 6, 2006. Violation of prior discipline. Negligent in assuring compliance with the regulations pertaining to the compounding of sterile products. Section 338.055.2 (5), (6), and (15), RSMo.

Drug Distributors

Agri-Med South, LLC, #2006017004, Troy, MO. August 7, 2006. Restricted drug distributor license issued on probation for two years. Distributed legend drugs without appropriate licensure as a drug distributor; dispensed a human legend drug pursuant to a veterinarian's prescription without appropriate licensure as a pharmacy, and selling legend drugs via the Internet without any type of licensure from the Board of Pharmacy. Section 338.055.1 and .2(5), (6), (13), and (15), RSMo.

The *Missouri Board of Pharmacy News* is published by the Missouri Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote voluntary compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

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